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The Canadian Medical Association and Health Insurance*

A Submission to the
SPECIAL COMMITTEE ON SOCIAL SECURITY
of the
HOUSE OF COMMONS
by the
CANADIAN MEDICAL ASSOCIATION
April 6, 1943

What is The Canadian Medical Association?

History records two notable events in the year 1867: (1) Canada became a confederation. (2) The Canadian Medical Association was founded for the following purposes:

(*a*) To cultivate the science of medicine and surgery.
(*b*) To advance the character and honour of the medical profession.
(*c*) To promote the public health.
(*d*) To elevate the standard of medical and nursing education.
(*e*) To assist in the advance of medical education for the good of the public.
(*f*) To study and advance by any means in its power, the improvement and standardization of hospitals.
(*g*) To conduct research work in connection with medical problems confronting the profession.
(*h*) To serve humanity and the medical profession by investigation, study and research.

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(*i*) To establish branches, to publish scientific literature and to do such other lawful things as are instrumental or conducive to the welfare of the public and the medical profession.

In 1909, the association became incorporated by Act of Parliament of the Dominion of Canada. Each of the nine provinces of Canada has a provincial medical association which is a federated division of the Canadian Medical Association. This means that the Canadian Medical Association, in a most democratic fashion, represents and speaks for nine provincial medical associations of Canada.

Membership in the Canadian Medical Association is voluntary, every Canadian doctor in good standing in his community being eligible for membership. There are registered in Canada approximately 10,600 doctors, 8,500 of whom are English-speaking and approximately 2,100 French-speaking. Of this total number, the Canadian Medical Association has 6,388 members, of whom over 300 are French-speaking. It will be observed that our French-speaking membership is numerically and relatively small. Why is that? There are a number of reasons which will also apply to other national organizations in Canada, but the most notable reason is the fact that the *Canadian Medical Association Journal*—a monthly publication—is printed almost entirely in the English language and therefore does not attract our French-speaking medical confrères who have splendid medical journals published in their own language. There is much evidence, however, to support the statement that the Canadian Medical Association in the province of Quebec is growing in influence and favour. In the province of Quebec a joint committee representing the various medical organizations, namely, the Quebec Division of the Canadian Medical Association, the College of Physicians and Surgeons of Quebec, and la Fédération de Sociétés Médicales, has been formed for the express purpose of studying health insurance and obtaining medical opinion on the subject. This committee has authorized the Canadian Medical Association to act as its spokesman in the matter of health insurance.

In respect to great national problems such as health insurance, the Canadian Medical Association has not been content in the other provinces to canvass its members only. On the contrary, the medical profession of Canada as a whole has been invited to make its voice heard in respect to these broad questions, to the end that it can be said without fear of contradiction, that the representations which the Canadian Medical Association now makes to this parliamentary select committee express the considered views of the medical profession as a whole throughout the Dominion.

The purpose of this submission is:

1. To emphasize that adequate medical care is essential to the welfare of Canada.

2. To review certain factors which handicap the medical profession in providing adequate medical care.

3. To point out that highly desirable preventive and public health services are now inadequate.

4. To indicate the position of the Canadian Medical Association with respect to state health insurance.

5. To set forth features which should be included in any plan of health insurance.

6. To point out the desirability of avoiding certain weaknesses observed in plans of health insurance in other countries.

7. To make general comments with respect to a number of features to be considered in setting up any plan of health insurance.

8. To show that health insurance can suffice to meet the medical needs of sparsely settled communities.

9. To discuss possible future developments in the years to come in the provision of good health care.

I. ADEQUATE MEDICAL CARE ESSENTIAL

It is most essential to the welfare of our people that the medical care provided be not only of the highest standard but be readily available to all. Although our present system of providing medical care is characterized by many desirable features worthy of retention, it is recognized that there are a number of ways in which provision is not made for the full needs of the people at the present time.

To achieve its full destiny Canada must have healthy citizens. Our people can only enjoy full and vigorous health if there be provided for them adequate facilities for medical care (preventive and curative) of the highest standard, which will be readily available to all, irrespective of geographic location and financial status.

It would appear that certain changes are necessary, and to achieve this result the medical profession stands ready to co-operate, for the welfare of the people has always been its primary objective. At the same time the profession is proud of the achievements of those who have laid the foundations of medical practice over the centuries. The medical profession has served the people well—caring for the poor, placing patient before self whether it be in time of plague or battle, developing medicine from discovery to discovery, fostering research, preserving what is perhaps the highest code of ethics in the world and attracting to its ranks many of the keenest minds of each generation. It is in the interests of our people that these features of medical practice be preserved.

II. HANDICAPS OR WEAKNESSES OF THE PRESENT SYSTEM

(a) The costs of sickness have become an increasing burden to many people, particularly those of moderate income, and have frequently prevented them from taking proper advantage of early diagnosis and treatment.

The extent and value and accuracy of medical knowledge and skill have increased tremendously, but at the same time the *cost* of this service has also become an increasing burden. The major increase has been due to the increasing complexity and delicacy of diagnostic methods and to the increased utilization of intricate apparatus and highly skilled personnel in treatment.

The diagnostic and "laboratory" equipment of Confederation days was limited to a stethoscope and (sometimes, not always) a thermometer. This equipment was the forerunner of the elaborate, complicated and costly, but highly accurate, equipment of our X-ray, pathological, biochemical and other laboratories. The number of hospital beds in Canada has increased from about 400 at the time of Confederation to over 100,000 at the present time. The hospital investment in Canada is of some $250,000,000. In five or six decades the cost of providing hospital service which would be abreast of expanding medical knowledge has gone up from 75 cents per patient per day to an average of around $3.00 per patient per day. The cost of medical education has increased five- or six-fold and the time required for it has been more than doubled.

Medicine has ceased to be a science in which any one man can expect to be able to offer full service. For special diagnosis or for certain curative measures, individuals with special knowledge in selected fields must be called in. This has increased accuracy of diagnosis and efficiency of treatment but has added to the cost.

True, it could be pointed out that the results attained have more than compensated for additional costs. Better and earlier diagnosis and more effective treatment have shortened illnesses and saved lives beyond computation. Actually, despite increased costs of hospitalization, certain specific illnesses, such as pneumonia, gall bladder operations, etc., cost the patient less for hospitalization today than at the turn of the century, due to a greatly reduced period of hospitalization. Moreover, costs of medical care have not risen as rapidly over the years as has the general cost of living. Nevertheless, owing to the unpredictability of most illnesses and accidents and the reluctance or inability of most people to budget for illness, some plan is necessary for relieving the individual of the burden of the cost of illness at the time when he can least afford to pay these costs.

The section of the community which has suffered most from the increase in cost is the great mass of honest, thrifty folk of moderate means. The so-called "indigent" has usually received the medical care he has needed and illness has seldom created a grave financial problem for the well-to-do. But for the man of low or moderate income who desires to pay his way, the possible costs have definitely deterred him in many cases from seeking early advice or agreeing to the proper treatment.

Voluntary medical and hospitalization plans. In an effort to alleviate the financial burden of sickness, a number of voluntary medical and/or hospitalization plans have been set up. The better hospitalization plans are known as "Blue Cross Plans". These voluntary contributory plans for medical care, or hospitalization, have been of much assistance to their members when overtaken by illness. Unfortunately, there are many areas where these plans do not operate; also, being of a voluntary nature they do not cover all of the employed people of moderate means. Moreover, they seldom provide a complete service nor do they make provision for those who are unable to make any contribution.

(b) The distribution of medical services in the various parts of Canada, urban and rural, is not as it should be if all of our people are to receive full and adequate medical care.

This applies also to health services in general.

A major problem in medical distribution is that of providing adequate medical care in rural districts. Present wartime conditions are abnormal and, therefore, cannot be taken as a basis of discussion, but long before the war it was obvious that there was a heavy concentration of medical practitioners and of health services in general in the urban areas. Now with large numbers of rural doctors in the armed forces, the problem is much more acute.

This situation not only makes active treatment difficult to obtain, but it interferes with preventive services. For years infant mortality has been much higher in rural than in urban areas; the same applies to tuberculosis.

Some concentration in cities logical. It should be pointed out, however, that, under any system, some concentration of medical personnel must be expected. Specialists could not be located other than in centres large enough to afford them an adequate clientèle; although located in centres, they serve both rural and urban patients. As the more technical or specialized diagnostic and curative procedures can best be done in hospitals, patients must continue to be taken to hospital for such purpose. Frequently the equipment or skilled personnel is only available in large urban hospitals. As it is neither possible nor advisable to set up fully equipped and staffed hospitals in all rural communities, many rural patients will continue to be treated in the larger centres, irrespective of any plan which may be put into effect.

Moreover, it has long been noted that many patients in rural areas, even though a competent physician be available in the community, will drive beyond him to the city for diagnosis or treatment. Resulting from the advent of the motor car and good roads, many doctors formerly able to make a living in a country community have been forced to move to larger centres.

Broad statements to the effect that a large number of rural municipalities are without medical care may convey an erroneous impression. A township or a municipality may not have a resident doctor, yet just beyond the borders of that area might be located several doctors serving the district in question with fully adequate care. Motor cars, improved highways and telephones have completely changed the former conception of what constitutes the geographic area for a normal rural practice.

(c) Many communities have failed to organize themselves in such a manner as to make the best use of existing legislation or to initiate their own health services.

Many communities have failed for various reasons to organize themselves to take full advantage of existing legislation which would permit them to develop much-needed health services. For instance, in rural areas with inadequate voluntary non-profit hospitals, more municipal or "union" hospitals would have greatly improved health services. For various reasons, among which might be cited economic conditions, lack of understanding and leadership, and even indifference, the public health services in many areas have often been but nominal, or even entirely absent.

III. PREVENTIVE SERVICES INADEQUATE

The present program of preventive medicine in the country is far from adequate. Our major emphasis in the past has been on the cure of disease—on

negative health, as it were. There should be more emphasis in the future on *positive* health, on preventive medicine and public health. It is less costly to prevent disease than cure it, yet our progress in this direction, although steady and gratifying, has been far too slow.

In making these statements there is no implication in the slightest that the provincial, federal and municipal departments of health have not done excellent work. Actually they have accomplished much, frequently under considerable handicap. But the results have been much less than could have been achieved had adequate funds been available. It is unfortunate that, while in the past money has been freely available for so many other purposes, yet so much difficulty has been encountered in obtaining adequate funds for effective programs of preventive work and public education on health matters.

HEALTH INSURANCE

IV. THE POSITION OF THE CANADIAN MEDICAL ASSOCIATION WITH RESPECT TO HEALTH INSURANCE

Realizing the situation, as already set forth, and that solutions for these difficulties must be found, the Canadian Medical Association has been actively studying the subject of health insurance for nearly fifteen years. In 1934 an outline of a possible plan of health insurance was drawn up and adopted by the Council of the Association. Studies continued and the principles upon which this outline was based have been reviewed and altered, or reaffirmed, from time to time up to and including the annual meeting of the Association in June, 1942.

Principle of health insurance approved. At a largely attended special meeting of the Council of the Canadian Medical Association held in Ottawa, January 18 and 19, 1943, the subject of health insurance was again considered. Previously the Council had said that if health insurance were to be established in Canada it should be along certain lines, but had refrained from recommending it or opposing it. At this time, and for the first time, the Council went further. In Ottawa in January, 1943, the Council endorsed the principle by passing the following resolution:

WHEREAS the objects of the Canadian Medical Association are:

1. The promotion of health and the prevention of disease;
2. The improvement of health services;
3. The performance of such other lawful things as are incidental or conducive to the welfare of the public; and

WHEREAS the Canadian Medical Association is keenly conscious of the desirability of providing adequate health services to all the people of Canada; and

WHEREAS the Canadian Medical Association has for many years been studying plans for the securing of such health services;

THEREFORE BE IT RESOLVED THAT

1. The Canadian Medical Association approves the adoption of the principle of health insurance.
2. The Canadian Medical Association favours a plan of health insurance which will secure the development and provision of the highest standard of health services, preventive and curative, if such plan be fair both to the insured and to all those rendering the services.

V. FEATURES WHICH SHOULD BE INCLUDED IN ANY PLAN OF HEALTH INSURANCE

We visualize for Canada a system of health insurance which will be more all-inclusive, efficient and sound than any which has ever been devised and operated anywhere. It should place much emphasis on the prevention of disease and the development of a high degree of physical fitness, and should also include complete modern diagnostic and curative services. Possibly this full program cannot be immediately instituted in its entirety, because of shortage of trained personnel and of institutions, and possibly because of cost, but the full service should be visualized and planned for. Medical knowledge in the prevention and cure of disease is far ahead of the means for its general utilization by the public.

It is obvious, too, that any plan of health insurance which is not supplemented by a program to ensure better nutrition, better housing and the reduction of worry and anxiety, particularly for those of low and uncertain income, will fail in its objective.

A. Adequate prevention and public health provision:

(i) Reorganization of public health and preventive services is necessary to place more responsibility for various procedures on the family practitioners. Their services must be available for and integrated with the public health officials' program. The family must be the unit and the family doctor the first line of defence in this program.

(ii) Our rapidly expanding knowledge of nutrition should be translated into action—adequate diets should be available to all. This implies not only a vigorous educational program but also a degree of economic security to which reference has previously been made.

(iii) The present knowledge of the value of *inoculations, vaccinations, and other immunizing and diagnostic procedures* in the control and eradication of disease should be fully utilized by the extension of public health services, operating with the assistance of the general practitioner.

(iv) General programs of *hygiene* and *sanitation* must be promulgated and carried out.

(v) *Periodic examinations* at suitable intervals should be available to all. The early recognition of disease is the greatest weapon in its mastery.

(vi) *Complete examinations of all children* should be linked with the means for correcting any deficiencies. This would greatly improve the health of our children.

(vii) A more general application of our present knowledge respecting goitre control could bring about a definite reduction in the frequency of this disease in affected areas. All such areas in Canada could be determined by careful study.

(viii) A well-organized program to control venereal disease is necessary throughout the country.

(ix) Fifty thousand Canadians are now suffering from cancer; more than 12,000 die of cancer annually, yet many, if diagnosed and treated early,

can be cured. An aggressive program to combat cancer should be an integral part of health insurance.

(x) Tuberculosis might be eradicated from Canada in 25 years if facilities were provided for its early recognition and efficient control.

(xi) *Maternal welfare:* Maternal deaths and disabilities have been markedly lessened, but could be reduced still further by a maternal welfare plan which would incorporate all those features which have proved to be of value.

(xii) *Full dental care for children* is a prerequisite to good health.

(xiii) *Pre-employment examinations* would help to direct individuals into employment which would be most suitable for them.

A progressive program for the improvement of the health and physical development of children and young people by supervised playgrounds and controlled exercises and physical-fitness programs is desirable. Also, the treatment of certain conditions is closely linked with the housing problem, and some integration of authority should be planned in this respect.

Such a general program would greatly assist in the fight to eliminate certain diseases such as diphtheria, whooping cough, tuberculosis, rickets, typhoid fever and smallpox, and would assist in the reduction in the frequency of many others, such as certain forms of mental disease, rheumatic heart disease, goitre, venereal disease and cancer.

As years pass, the cost of curative services might be expected to materially decrease as disease is controlled and physical fitness increased.

B. General practitioner services: The fundamental service should be general practitioner service. When medical services are needed, such should be available without cost to the patient at the time. The individual should have the right to choose his medical adviser, and vice versa.

C. Specialists and consultants: The science of medicine has progressed so rapidly that many conditions call for investigation and treatment by adequately trained and recognized specialists and consultants. This service is invaluable and must be freely available.

D. Additional diagnostic services: There should be available for all the people whatever diagnostic aid would be of value. This should include laboratory, radiological and other scientifically recognized diagnostic procedures and should also include consultant services. If necessary, diagnostic facilities should be set up to serve designated areas. In some cases the pooling or centralizing of some of these diagnostic services could reduce overhead and consequent cost.

All necessary diagnostic aids which have been proved to be of scientific value should be available for all the people.

E. Hospitalization: Hospitalization accommodation should be available to all who need it and for such time as they need it.

F. Nursing: A visiting nurse service should be available in the home on the order of the medical adviser. Full-time nursing service should be made available upon the authorization of the regional medical adviser.

G. Drugs and appliances: Drugs and pharmaceutical preparations, as authorized in an official formulary which could be prepared, should be available upon the order of the medical adviser. Appliances, such as spectacles, crutches, artificial legs, etc., should be available within reason when authorized.

H. Dental services: Dental prophylaxis and care with a stipulated limit should be available to all.

I. Problems needing special attention: There is considerable need for the development of adequate facilities for the rehabilitation of those partially incapacitated by physical and mental illness. Such a program would be both humanitarian and economically sound. There is need, too, in every province in Canada for more homes for the care of the aged and the infirm. This also applies to the care of those who are chronically ill.

VI. WEAKNESSES OBSERVED IN PLANS OF HEALTH INSURANCE ELSEWHERE SHOULD BE AVOIDED

In the setting up of any health insurance measure in Canada, it is highly desirable that we profit by the experiences of other countries. Their health insurance enactments have been studied carefully by our Association. To obtain first-hand information, the Canadian Medical Association sent its General Secretary to Europe in 1937 to study health insurance in operation.

The following weaknesses and omissions observed there and elsewhere should be avoided in Canada:

(a) Limited range of service in some countries: A plan which provides for general practitioner service only does not provide a complete service. Such arrangement is not fair either to the patient or to those who must render specialist service. By not providing for hospitalization, patients are either unable to obtain needed hospitalization, or must bear heavy financial burdens, or must accept charity. All too frequently an insurance scheme thus becomes a charity scheme.

(b) Dependents not covered in some plans: To omit from benefits the dependents of the insured, still requires the breadwinner to finance the major portion of sickness in the average family (somewhat over two-thirds of the total hospitalized illness in a family with two children and a still higher proportion—nearly four-fifths—in the case of home and office practice).

(c) "Indigents" not covered in some countries: The inclusion only of those who are employed, or who receive up to a certain income, still makes no provision for the varying but usually large number who are in the group frequently referred to as "indigent" or "near-indigent". From the viewpoint of national health, and particularly from that of preventive medicine, it is most important that this group be covered.

(d) Friendly societies as "carriers" found undesirable: The utilization of Friendly or Benevolent Societies as carriers under the Act in one large national plan has had unfortunate results. Although politically expedient at the time to obtain support for the measure, it has now become obvious that these carriers have introduced a third party between patient and physician and between citizen

and government. Over the years these carriers have developed large surpluses and have now become so powerful that, through their membership, they can dictate to the government in insurance matters. In another country they have "played politics" and have been more concerned with the competition for members than with the medical services rendered.

(e) Inadequate payment for services rendered: Inadequate payment for services rendered can be of serious concern to the general public, for eventually it will result in a lowering of the quality of the service rendered. Physicians, dentists, nurses, technicians and all those rendering specialized or expert service should be compensated in accordance with their investment of time and money in initial and post-graduate training, and with their responsibilities and the arduous nature and dangers of their work. It is vitally important to the health of the nation to ensure that medicine of the future shall continue to attract a large percentage of the keenest young men and women of each generation.

(f) Inadequate provision for necessary diagnostic services: Some plans do not make provision for adequate diagnosis, such as laboratory and X-ray examinations and consultant services. When required these must be paid for by the patient or, as is frequently the case, be provided on a charity or part-pay basis by hospitals and consultants. This is not conducive to early diagnosis, effective treatment and prompt recovery.

(g) Lack of democratic principles in some plans: In one well-established plan in a major European country the methods adopted are exceedingly dictatorial and bureaucratic and permit the individual member or those rendering the service little, if any, opportunity for stating grievances or correcting omissions or abuses. Health insurance should be a well-integrated partnership, with all parties concerned—the insured, those rendering the services, and the state—given a voice in its direction.

(h) Preventive medicine and public health not emphasized in other plans: Of utmost importance, most existing plans of health insurance do not lay sufficient stress upon preventive medicine. The emphasis has been largely upon curative medicine. Canada has an opportunity to develop a system of health insurance which, by the inclusion of the preventive features already mentioned, can not only set new standards of health legislation, but can have an effect on our future national health far beyond our comprehension.

VII. ADDITIONAL FEATURES TO BE CONSIDERED IN ANY PLAN OF HEALTH INSURANCE

(a) In developing a health insurance plan in Canada great care should be taken to ensure that the proposals are sound and sufficiently comprehensive.

The medical profession recommends a complete service of high standard. To the medical profession it will mean great and in some respects unwelcome changes. We are, however, willing to assist in its formation and its operation, *provided* that it will secure for all the insured a high standard of service, as high as or higher than has been available in the past, and will be fair both to the person insured and to those rendering the services.

(b) Should health insurance be a strictly federal measure or should it be a provincial measure, operating under federal enabling legislation and with federal assistance?

We realize that there are advantages in a single nation-wide measure of health insurance. It does appear, however, that there are certain factors which would indicate that health insurance should be introduced on a provincial basis. Provincial plans should be co-ordinated by federal legislation of an enabling nature. Such federal legislation should outline those standards to which provincial enactments would be expected to conform in order to receive federal subsidies. Our reasons are as follows:

1. Local conditions, such as costs of living, needs for and costs of services, incomes, etc., vary in different provinces.
2. It would be much more difficult to draft a federal measure acceptable in detail to all parts of Canada, than to prepare a federal measure which would outline the general provisions only and leave many of the details to be determined in the individual province.
3. By maintaining uniformity in the general structure of the plans to be developed in the different provinces, the problems of later unification, should that prove desirable, would be simplified.
4. Revision of the British North America Act would not be necessary.

Some form of federal control essential for uniformity: If provincial autonomy is to be maintained as suggested above, it is extremely important that a sufficient degree of federal control be retained. This control should be limited to such matters as the extent and the standards of the services, as indicated previously. It is important, however, that control be maintained, as it is only through this means that a satisfactory degree of uniformity can be obtained. Unless there is considerable similarity in methods and program in matters of disease prevention and control, the results from the national viewpoint will be jeopardized.

(c) Administration.

FEDERAL. If the federal legislation passed be of an enabling nature, it would follow that the function of the federal government with respect to provincial enactments would be broadly to supervise the operations of these provincial acts in order to determine the eligibility of the provinces to receive the federal subsidies and other assistance provided under the Act.

On this basis it is recommended that the federal administration be under the Minister of National Health, with an Advisory Dominion Council on Health Insurance.

If federal administration is to be carried out within the Department of Pensions and National Health it should be under a Health Insurance Division, with a director in charge.

PROVINCIAL. In the provinces it is strongly recommended that the plan come under a NON-POLITICAL INDEPENDENT COMMISSION which might be responsible to the legislature through the Provincial Minister of Health. Because

of the vital nature of health care the Canadian Medical Association considers it highly desirable to remove these important health services from the possibility of interference in the continuity of services or personnel by the vicissitudes of political change.

We believe, moreover, that the Commission should be so constituted, appointed and empowered that it will possess ample freedom of action and that its members will be representative of and preferably nominated by the various professional and other groups interested in the operation of the Act.

(d) Certain details might wisely be left to the Province.

Among these might be: (i) The income level (which might be high enough to include all the residents, or set at an agreed level which might vary in the various provinces) below which the residents would be included under an obligatory plan; (ii) the rate and method of payment for all services, professional and institutional; (iii) the best means of obtaining full preventive and public health services within the province concerned; (iv) the particular means which might be necessary to safeguard the basic necessity of maintaining adequate teaching services in connection with Medical Faculties and teaching hospitals within the province.

(e) The patient of little or no income should be included.

Those patients, frequently termed "indigents", who cannot pay for adequate health services should be included. It would be grossly unfair, not only to the public, but also to those rendering the health services, to omit this group from the benefits of the plan. Provision for the inclusion of such patients should be specifically made in the Federal enabling and Provincial Acts.

(f) The plan should be on a contributory basis.

The principle of having those participating in the benefits contribute to the fund would seem to be sound. The individual who shares in the cost of providing the benefits is much more likely to co-operate in keeping down unnecessary calls upon the fund. For those not employed by others, a basis of direct assessment could be worked out.

(g) Remuneration.

The remuneration of those rendering the services required under this plan should be reasonable and in conformity with the high standards of service expected of them. In the case of the medical practitioner (general practitioner), it is obvious that some variation in the basis of remuneration may be necessary in different areas. In some areas a "fee-for-service" basis may be desirable; in others a "capitation" basis (so much per annum per individual on a panel, irrespective of the amount of service rendered) may be preferable; in other areas, particularly certain rural areas where the population is small and scattered, a "salary" basis, or a combination of any two of these three alternative methods, may prove desirable. Because of this situation it is recommended that the method of remuneration, as well as the amount, be left for decision in the individual province after consultation between the Commission and representatives of the medical profession.

In the case of the specialist or consultant it would seem necessary to follow a fee-for-service basis.

(h) Medical education must be maintained at a high standard.

Fully trained medical personnel in sufficient numbers are absolutely necessary to any plan of general health insurance. Such are necessary for the health welfare and the future of the nation. If anything happens to the proper teaching of succeeding generations of doctors, scientific medicine dies and with it declines the health of the nation. The truth of this assertion is obvious.

Heretofore clinical teaching has been carried on in wards set aside for that purpose; these have usually been the public wards of our large teaching hospitals. The hospital service has either been free to the patient or at minimal rates and the medical attention has been without charge. Although the patients have been available for the bedside discussion and demonstration of methods of examination and treatment, the service has been of the highest standard of excellence and always with the complete co-operation of the patients concerned. Under a health insurance plan in which there would be no longer any group of individuals who would receive so-called "free treatment", there is a possibility that opportunities for clinical teaching may be reduced. While it is anticipated that the long-recognized excellence of the quality of diagnosis and treatment in teaching hospitals may alone suffice to ensure a sufficient number of patients, it must be recognized that it is distinctly in the public interest that the popularity of teaching hospitals should be maintained, to the end that teaching may not be curtailed.

(i) The plan should be on an obligatory basis for the income groups specified and should be without exceptions.

In other words, all persons coming within the income brackets stipulated should be required to contribute to the Fund and be eligible for benefits and there should be no provision for the exclusion of groups below the income level set for the operation of the Act.

Much of the value of a fully adequate scheme lies in its *preventive* services. The entire population benefits from the functioning of these services and should contribute to them. Conversely, if preventive measures are not applicable to any groups in a community, not only do these groups suffer, but they may constitute a health menace to others.

There are certain plans operating in parts of Canada with voluntary prepayment for health services, providing either medical care or hospital care, or both. Some of these plans are excellent—as far as they go. But none of these plans, to the best of our knowledge, offer the complete protection—preventive, diagnostic and curative—which we believe is envisioned in this proposal. Some of these plans do not cover dependents. Others cover dependents but, in one-industry towns, may not cover the scattered townspeople not directly connected with the plant. Any acceptable national or provincial plan should offer more than can any individual plan. These plans deserve great credit for their pioneering service but it is in the national interest to have all single plans absorbed. With a government subsidy, the resultant cost to these industries should be less than under present conditions.

It has been the experience in other countries, notably Great Britain, that the exclusion of certain groups of individuals and the utilization of existing plans have complicated the situation and made it more difficult to attain ideal results. From the viewpoint of administration, a multiplicity of local arrangements, perhaps overlapping in the one community, creates a situation so chaotic that efficient operation becomes very difficult. Another difficulty arises when an individual changes his employment or moves to another town. If Canada is to have health insurance, let its action be not hamstrung by lack of vision or courage.

There are within Canada, also, certain groups who do not accept medical services—at least at times. They all, however, have been the beneficiaries of preventive and public health services and most of them, sooner or later, of diagnostic and treatment procedures as well. Apart from this, however, all our citizens have a *common community obligation*. There is probably no argument which can be advanced in support of the exclusion of certain groups from participation in any plan which was not advanced two or three generations ago in opposition to the inclusion of the general population in a scheme under which all were taxed to support our great public school system, even though all do not avail themselves equally of its privileges. It should be quite proper, of course, for certain individuals, if they so desire, to obtain their health care outside of the provisions of any insurance scheme, even as individuals now use schools which are apart from those provided under the authority of our Public or Separate School Acts.

It should also be proper for any institution or any member of any profession to decline to act under the plan and to offer services in a private capacity under any arrangements which are agreeable to themselves and to their patients, provided these arrangements are not contrary to public interest.

(j) If cash benefits be provided for loss of time through illness, such should be through a separate fund entirely apart from the health insurance fund.

Cash benefits, obviously, are a matter of great importance to the insured. It is entirely true "that a person sick needs financial assistance more than a person well". This is realized, yet from the viewpoint of conscientious medical service cash benefits incorporated in health insurance have introduced serious complications.

In every country where cash compensation for loss of time has been a part of a sickness insurance plan, there has been great dissatisfaction over the complications of operation which have developed, and the drain on the common fund because of its inclusion. Because of experience gained in other countries operating a health insurance plan, we strongly recommend that such assistance be provided through some plan to be devised *entirely apart* from the health insurance plan.

VIII. CAN HEALTH INSURANCE MEET THE MEDICAL NEEDS OF SPARSELY SETTLED COMMUNITIES?

The answer is, yes. In areas where a doctor could not make an adequate living on the ordinary basis of remuneration under the plan, the Commission

could provide a salary adequate enough to prove attractive to our doctors. If district nursing service be provided, as well as adequate diagnostic and reasonable hospitalization facilities, and if reasonable opportunities to get away for post-graduate study or for vacation be made available, our doctors will go to rural areas. If bursaries be made available to permit brilliant young people without adequate financial means to complete the medical course, their services in such areas for a definite period of years could be required. The same effect could be obtained, as has been done in Australia, by offering young men and women opportunities for post-graduate study upon the completion of a definite period of service in rural communities.

IX. HEALTH AND HEALTH PRESERVATION IN YEARS TO COME

During the past two generations more progress has been achieved in making good health care available to all than for the two previous centuries. We anticipate still greater progress in the years to come.

Improved facilities for diagnosis: Better and more readily available diagnostic procedures will do much to still further reduce illness. It is hoped that the present commendable system in many provinces of having certain swabs, smears, blood samples, etc., examined by the Department of Health will be extended. The setting up of branch laboratories has been of tremendous assistance. The establishment of "diagnostic centres" in strategic locations may be anticipated. These could be governed by adequate regulations relating to the nature and quality of service, charges and remuneration and to ethical relations. As the inclusion of people of inadequate means under a health insurance plan may make most hospital outdoor departments unnecessary, some of these facilities might be converted into "diagnostic clinics" or centres for referred patients.

Rural medicine: Rural medicine will be better organized in years to come. Good care must be available to all. This does not mean that a highly trained doctor must sit around waiting for a handful of scattered settlers to call for his services, but it does mean that methods will be worked out whereby "positive" health care can be made available to these people. This can be accomplished by adequate district nursing, by a reasonable system of rural hospitals, and by providing doctors with sufficient returns to compensate them for the hardships and strain of that type of practice. This will all be made easier by providing good roads and improved methods of transportation.

As for *specialist* and *consultant services,* there is no reason why such cannot be made available to rural areas. To a large degree the removal of the economic barrier and better transportation will permit readier consultation at the doctor's office. The bigger problem—that of bringing the specialist or consultant to the rural patient—could, and may be, overcome in a fashion similar to that evolved some years ago in Australia and now widely utilized in military medicine; that is, by aerial transport. The day may not be far distant when health service planes could be made available in selected areas to carry specialists and consultants, or even "surgical teams", to seriously sick or injured patients. The same planes

could function as "aerial ambulances" to carry patients to hospital. The helicopter type of plane would be particularly valuable for this purpose.

Health centres: In certain areas, we can foresee the creation of "health centres", such as have been envisioned by the British Medical Planning Commission in its constructive report in 1942. In essence the proposal is as follows:

The health centre would be a building providing a series of consulting rooms, waiting rooms, a small operating room for minor surgery, laboratories and other accommodation. The general practitioners in the town, or that part of a city, would use these facilities for their office consultations. They would not be in partnership, as in a clinic, but would merely use these facilities in a co-operative manner. Each doctor would have his own patients who in turn have exercised their right to select their own medical adviser. Specialists would see patients either in the centre or elsewhere. Serious or more difficult cases would be sent to the hospital. Work of the centre would be preventive and educational, as well as diagnostic and curative.

The X-ray department and the laboratories would be available to all participating doctors: so would the dispensary, the secretarial department and the clinical records department. Health visitors and district nurses would have their headquarters at the centre.

A large city might have a number of these centres. We might add that where a hospital is centrally located it would be quite possible to have such an office building adjacent to or part of the hospital itself.

Hospitals: Our present hospital system is excellent, but it will probably show better integration in the years to come. We sincerely hope that we shall always continue to benefit from the services of the great group of voluntary hospitals, lay and religious, which have served our sick for many years. It should be possible, however, without jeopardizing this system, to have hospital construction and equipment in general follow a carefully planned program based upon provincial and community needs rather than upon unrelated and sometimes overlapping local efforts.

Specially designed hospitals should be available in rural areas. These should not be made more elaborate than is justified by local needs, by professional and technical staff available and by the proximity or otherwise of similar or better facilities. Nor should they be more numerous than is necessary to meet local conditions. As transportation facilities improve, the need for numerous rural hospitals should decrease rather than increase. Moreover, if rural and urban hospitals could be so linked that patients could be quickly transferred, when necessary, to institutions with more elaborate equipment, the net result should be a reduction of mortality, more rapid convalescence and a definite saving of both skilled personnel and special equipment.

One regrettable gap in our present facilities will surely be corrected, that is, more hospitals for convalescent patients and for those suffering from chronic or incurable illnesses. Actually such provision would be a distinct economy.

Should these improvements be combined with general increase in social

security and health planning—assured employment and maintenance, better nutrition, better sanitation, better housing and planned physical programs—the improvement in national health would be amazing.

CONCLUSION

Throughout the last ten years, the Canadian Medical Association has consistently and repeatedly sought to ascertain the opinion of the medical profession on the subject of health insurance. The views expressed in this submission crystallize those opinions.

Since this memorandum was prepared, there have been placed in your hands the draft proposals of the Advisory Committee on Health Insurance. While some of us have had the opportunity of seeing these proposals, they have not been seen by our constituent societies. It is our hope that in the immediate future the medical profession throughout Canada will be permitted to examine these proposals in detail and that shortly thereafter we may be in a position to come back to you to discuss those aspects of the proposals upon which you might desire our advice and opinion.

In conclusion, the Canadian Medical Association desires to assure the Special Committee on Social Security that our entire organization stretching from sea to sea stands ready to render any assistance in its power towards the solution of one of the country's most important problems; namely, the safeguarding of the health of our people.

The Importance of Preventive Medicine and Public Health in National Health Insurance

A Submission to the
SPECIAL COMMITTEE ON SOCIAL SECURITY
of the
HOUSE OF COMMONS
by the
CANADIAN PUBLIC HEALTH ASSOCIATION
May 21, 1943

The Canadian Public Health Association—Its Organization and Purposes

THE Canadian Public Health Association was organized under Dominion charter in 1912 and is a professional society, representing those who are rendering public health service through official departments or voluntary agencies. Its membership includes physicians serving as medical officers of health throughout Canada, members of the dental, nursing and engineering professions, and other professionally trained personnel serving in this field. In the thirty years of its work, the outstanding leaders of public health have served as its officers. It therefore presumes to speak for those who are most familiar with the actual conduct of public health services throughout Canada.

The Canadian Public Health Association has consistently stressed the need for health insurance, and reaffirmed its advocacy of a national plan in the following resolution which was adopted at the Association's thirty-first annual meeting in Toronto in June 1942:

"Whereas there is urgent need in Canada for the more adequate provision of general medical, dental, and nursing service,

"And experience in Great Britain and other countries has demonstrated the value of a system of compulsory, contributory health insurance,

"And this Association believes that in any health insurance program adequate provision for preventive services is essential,

"Be it resolved that this Association endorses the principle of national health insurance and urges that the provision of preventive services should form an essential part of this program."

The Purpose of this Submission

The purpose of this submission is to show:

1. That preventive medical services are essential to the success of health insurance.
2. That all parts of Canada must have adequate local health services.

3. That the practising physician should provide both preventive and treatment services; and that, to render these services, he must have assistance from an adequate local department of health.

4. That adequate local health department services depend on provincial departments of health for direction and for financial assistance.

5. That grants-in-aid from the Federal Government offer the solution of meeting urgent public health problems, particularly the control of tuberculosis, treatment of mental illness, and control of venereal disease, and the development of adequate local health department services to cover all parts of Canada.

6. That it is essential that health insurance and public health be integrated both in provincial and local administration.

7. That qualified public health personnel are required in the conduct of public health work and provision for assisting in their training is necessary.

8. That more adequate support of medical research in Canada is essential to the progress of medicine and the success of health insurance.

1. THE INCLUSION OF PREVENTIVE MEDICAL SERVICES IS ESSENTIAL IN AN ADEQUATE PLAN OF HEALTH INSURANCE

The term "health insurance" implies provision for maintaining and promoting health. Unfortunately, health insurance measures in effect in various countries have related almost exclusively to the treatment of sick persons and the provision of assistance while they are unable to work. Obviously this type of service is merely provision for medical care and sick benefits—*sickness insurance*, and not health insurance. Unless due provision is made for the inclusion of adequate preventive services, the term "health insurance" is an obvious misnomer. The success of health insurance depends, therefore, on the inclusion of public health and preventive medicine.

The failure to distinguish between health insurance and sickness insurance is not suprising, since public health services and preventive medicine are developments of the past few decades. The conception that, in addition to providing treatment in case of sickness, physicians should supervise the health of families under their care has been growing in recent years, and many physicians now consider this to be part of their obligation to the family. The preventive aspects of dentistry have been accepted for some time and are appreciated by the public as a result of the widespread attention drawn by the dental profession to the importance of such care.

It is illogical to allow preventable diseases to continue to occur and then have to provide for all the costs and suffering associated with treatment. All diseases and conditions which result in disability or death, and which may in part at least be prevented, should be vigorously attacked in order to reduce their incidence to a minimum. Medical science has enabled great advances to be made in the prevention of certain diseases and has provided essential information in regard to the fundamental requirements for the maintenance of health. Broadly speaking, the large group for which prevention is possible consists of all

communicable diseases, diseases due to faulty nutrition, diseases arising out of occupations with definite health hazards, and illnesses and disabilities associated with maternity. Prevention results in the saving of many lives, as well as in reducing the extent of sickness and disability. The whole of the "safety first" movement is a recognition of the necessity of reducing preventable disabilities and deaths from accidents.

Much has been accomplished through the adoption of preventive measures by organized departments of health, practising physicians, nurses, and dentists; and in this work the voluntary health agencies have made important contributions. Such results as the reduction in the death rate of tuberculosis in Ontario to less than one-fifth the rate of 1900, of typhoid fever to one-fiftieth the rate of 1900, and of diphtheria to one-eighty-fifth of the 1900 rate, are illustrations of what has been accomplished. There has been a marked reduction, too, in the number of infants dying in the first year of life, so that the infant mortality rate for the whole of Canada has fallen from 93 per thousand living births in 1926 to 60 in 1940. These great reductions in the number of deaths of infants and young children have resulted in an increase in the life expectancy. In the United States the life expectancy in 1900 was 49.2 years and this has risen to 63.7 years in 1942, representing an increase of 13½ years. Canadian data indicate a similar increase in life expectancy. As stated, the increase in life expectancy is due primarily to the great reductions in the number of deaths in infants and young children. Gratifying as are these reductions in sickness and deaths, much remains to be done. In Canada in 1941 there still were recorded 6,072 deaths from tuberculosis (all forms), 165 deaths from typhoid fever, and 240 deaths from diphtheria. Each of these diseases is preventable and every case results in the needless exposure of other members of the community.

Prevention is Cheaper than Treatment

Preventive services cost much less than treatment services. A study was made of the cost of diphtheria in Ontario for a year when diphtheria was very prevalent before prevention was possible through immunization with diphtheria toxoid. In 1924, 3,073 cases were reported, with 322 deaths. Costs of hospital care in various cities for the treatment of some of these cases, together with an estimate of the cost of medical care at home, amounted to $300,000. In contrast, the cost of giving the preventive treatment of diphtheria toxoid *to ALL the pre-school and school children in the province* would have been but a third of this amount. When it is remembered that such immunization does not have to be repeated yearly, but only a "reinforcing" dose is required a few years later, the significance of the difference in the cost of treatment and preventive services is appreciated. If an estimate of the actual cost to Ontario were made, it would have to include the estimated economic value of the 322 children and young adults who died, together with other costs. Such an estimate would represent several millions of dollars. In Ontario in 1941 the cost of treatment of 6,666 patients in tuberculosis sanatoria amounted to $2,794,935. Only a fraction of this amount

is spent in the discovery and examination of contacts, tuberculin testing, and mass X-ray examination, all of which form an essential part of the control program.

In such instances as the loss of life from diphtheria, tuberculosis, and typhoid fever, the results and shortcomings are comparatively easy to assess. In other instances, where the application of preventive measures is less direct, much may still be achieved. For example, an important cause of death in persons under fifty is rheumatic heart disease. According to recent surveys, more deaths in persons under 20 years are due to this cause than to pulmonary tuberculosis. Rheumatic heart disease is a disease which is characterized by repeated attacks over a period of years. It is generally agreed that a large proportion of the disability and deaths can be prevented by adequate supervision of persons who have already had one attack. Although this requires the provision of sufficient hospital beds and other facilities, the most important factors are the early recognition of cases, and the close and prolonged supervision of individual patients which can best be done by the physician in private practice who is the first and often the only one who is aware of the condition. The importance of efforts in rheumatic fever lies in the fact that it is one of the chief causes of heart disease in later adult life, and if the incidence and mortality of heart disease are to be reduced, attention must be paid to this disease.

The Canadian Public Health Association visualizes, with the Canadian Medical Association, " a system of health insurance which will be more all-inclusive, efficient and sound than any which has been devised and operated elsewhere. It should place much emphasis on the prevention of disease and the development of a high degree of physical fitness, and should also include complete modern diagnostic and curative services."

Adequate preventive and public health provisions are outlined in detail in the Submission of the Canadian Medical Association (Minutes of Proceedings and Evidence, No. 5, pages 138 and 139). The statement concludes as follows:

"Such a general program would greatly assist in the fight to eliminate certain diseases such as diphtheria, whooping cough, tuberculosis, rickets, typhoid fever and smallpox, and would assist in the reduction in the frequency of many others, such as certain forms of mental disease, rheumatic heart disease, goitre, venereal disease and cancer.

"As years pass, the cost of curative services might be expected to materially decrease as disease is controlled and physical fitness increased."

It is evident therefore that the conception of health insurance which this Association shares with the Canadian Medical Association is one in which preventive services and public health occupy a most important place. In such a conception, *the benefits of health insurance must be made available to everyone.* It is significant that the representatives of labour, agriculture, national and local organizations of women, and the dental and nursing professions, all agree that the need in Canada is for *health insurance* and not merely *sickness insurance* which provides chiefly for the treatment of disease.

Preventive medicine and public health are directed not only towards the

lengthening of life through the prevention of disease and premature death, but also towards all that pertains to health, both physical and mental. Social measures that give security, and free individuals from anxiety, make an important contribution to health. Likewise, the contribution of social workers and the provision of playgrounds and programs for physical fitness render essential service in promoting health. In this conception, adequate local health services can only be provided through the physicians, nurses, dentists and the organized local departments of health and the community's welfare organizations.

2. ALL PARTS OF CANADA MUST HAVE ADEQUATE LOCAL HEALTH SERVICES

The program of health insurance that has been outlined calls for adequate community (local) health services which are to be provided by the medical, dental, and nursing professions in co-operation with the organized department of health and with the assistance of local voluntary health agencies. To reduce the ravages of disease there must be an adequate and scientifically directed attack on the sources of disease and on those conditions which favour the occurrence of disease. *Every part of the country should be served by an adequate local health department.* Unfortunately, only part of Canada, and that chiefly the urban sections, has local health services under the direction of a medical officer of health who is paid for full-time service. Service rendered on a part-time basis is almost always insufficient and fails to protect the community when epidemics threaten or other emergencies arise. The greater part of the rural areas make inadequate provision for public health services. The need for such services is not confined to the more densely populated communities. In fact, the present need for more adequate sanitary facilities is generally in inverse proportion to the density of the population—the poorest sanitary conditions often being found in the smaller towns, villages and rural communities. Where the need, therefore, is the greatest, the ability of the communities to provide services is frequently the least. The necessity for strong community health departments for the control of communicable diseases, including tuberculosis and the venereal diseases, needs no emphasis. Similarly, the necessity for the regular supervision of perishable foods is obvious.

It is recognized that certain essential preventive services are now being inadequately carried out even in municipalities with well-organized local health departments. In small communities no provision whatever is officially made for essential preventive services for the expectant mother, the infant, the preschool child and the school child. It is recognized that the practising physician should render prenatal supervision and continue health supervision of the infant and child. Considering Canada as a whole, it is probable that not more than 40 per cent of expectant mothers are reasonably well cared for during the period of pregnancy in so far as prenatal supervision is concerned. In the matter of infant hygiene, probably not more than 20 to 30 per cent of infants are receiving any acceptable type of medical supervision, either from public or private agencies

or the private practitioner. Since these estimates relate to the whole of Canada, including large urban centres which generally are better served, the percentage of expectant mothers receiving prenatal care and of infants under health supervision must, in the villages, towns and rural areas, be small indeed. It is recognized that this percentage could be substantially raised if adequate local staff, both medical and nursing, were available and if the family physician could more generally assume this responsibility.

The pre-school age group is generally not receiving health supervision either through the local department of health or from the family physicians. Supervision of school children is provided in large centres of population but is almost entirely lacking in communities in which the service is rendered by a part-time medical officer of health and the local department of health is a minimum in organization and resources.

Local Health Services in Canada

In general, it has been required, under the Public Health Acts of the various provinces, that every community, village, town, township or city, shall have a local board of health, a medical officer of health (usually serving part-time), and at least one sanitary inspector. In Ontario, for instance, there are 575 medical officers of health serving 900 communities, including 32 cities (in many instances the same medical officer serves several communities), and of this number only 16 are paid for full-time service. As noted, the great majority of medical officers of health are serving on a part-time basis, receiving a few hundred dollars or less for their duties in this capacity.

As previously stated, part-time service generally is found to be inadequate, even in small municipalities. The part-time medical officer of health cannot initiate preventive services because there is no staff to assist him, such as trained public health nurses or competent sanitary inpectors. There is no health department office apart from the physician's private office and in consequence few, if any, records are maintained. In fact, it is difficult for a physician engaged in private practice to discharge the duties of medical health officer without incurring disfavour when disciplinary action is required in the correction of faulty sanitation or in the control of communicable diseases. Such disfavour is not conducive to a successful private practice. Thus it is recognized by public health leaders that the direction of local health department services must be provided by a physician with special training in public health, giving his full time to the department.

How then is such service to be provided for those communities that are not large enough to maintain full-time health services?

This problem has been the subject of much study and trial on this continent and in Great Britain. Three methods of providing full-time services are in use in Canada. These represent in each instance the participation financially of the provincial government to a greater or lesser extent, varying from 20-30 per cent to 90 per cent of the total expenditure. The plans in use in Canada are: 1, health districts; 2, health units; 3, metropolitan health areas.

1. *Health Districts.* The province of New Brunswick is divided into ten health districts representing either a single county or several counties. Included in these districts are the cities and towns. The provincial government assumes the responsibility for the appointment of a qualified medical officer of health for each district. Approximately one-third of the cost of these district health services is met by the counties concerned. There are no local health officers in New Brunswick and the province is therefore served by ten full-time medical officers of health. Although the staff supplied in these districts is inadequate in so far as nursing and other personnel are concerned, the plan permits of additional staff being appointed by the provincial department of health when sufficient funds are available and trained personnel can be obtained. The responsibility for the organization and its direction is primarily placed with the provincial department of health, and the local community's contribution relates to the providing of local secretaries, offices, etc.

2. *Health Units.* In certain provinces of Canada, counties are administrative divisions, whereas in other provinces the unit of administration is the municipality. Health units providing full-time health services may embrace part of a county, a whole county, two or more counties, or two or more municipalities, depending on the density of the population. The population to be served by a health unit should not be less than 10,000 and preferably not more than 100,000.

A committee of the Canadian Public Health Association dealing with full-time health services has outlined a public health program for a population of 100,000, indicating the services to be rendered and the reasonable minimum personnel required. These requirements constitute a yard-stick, and proportionate personnel and expenditures apply to smaller units of population. The population of 100,000 combines rural and urban areas, in a proportion of rural and urban in the ratio of 2 as to 3, the urban population being considered as including towns and larger centres. On the basis of these standards, an area of 1,000 square miles having a population of 30,000 would be served by an organization consisting of a full-time medical officer of health, five nurses, two sanitary inspectors, and office assistants.

At the present time four such units have been organized in British Columbia, nine in Alberta, three in Manitoba, one in Ontario, fifty-one in Quebec and five in Nova Scotia. Prince Edward Island, as at present organized, consists of one unit.

It is generally agreed from the extensive experience on this continent with full-time units that adequate services require the expenditure of $1.00 per person per annum. Generally speaking, local communities contribute from one-quarter to one-half the total cost of the services, the provincial health authority supplying the balance. Since the public health authority assists substantially in meeting the cost of the services, the responsibility for the selection of trained personnel and for the direction of the program is placed with the provincial department.

3. *Metropolitan Health Areas.* It is well known that the suburban areas adjacent to large cities frequently present urgent public health needs. In

accordance with the general provision in Canada for local health services, each suburban municipality endeavours to provide some type of local services with part-time staff. A half dozen or more municipalities may be contiguous to a city, and it is obvious that economy and efficiency would result if a metropolitan health area embracing the city and the adjoining municipalities were established. Such a metropolitan area has been planned and in large measure achieved for Vancouver and its environs, through the active support of the Provincial Board of Health of British Columbia and with assistance from the Rockefeller Foundation. Consideration is being given to similar organization by several other cities.

Municipal Doctor Plan. As evidence of the efforts to meet better the local community needs, the introduction of the so-called municipal doctor plan in Saskatchewan and Manitoba is of interest. Approximately one-third of the municipalities in Saskatchewan have made arrangements whereby medical care is provided through the appointment of a salaried physician who serves also as medical officer of health. In Manitoba a number of communities have similar provision. This plan is primarily a plan for the provision of medical services.

It is evident, therefore, that the best method of providing full-time local health services has been determined by trial in the various provinces. Whether provided by health districts, largely financed by provincial departments of health, or by smaller health units in which the local community assumes a larger financial responsibility, the provision is made for properly qualified public health personnel serving on a full-time basis.

The Extent of Full-time Health Services in Canada

To what extent is Canada provided with full-time health services? To answer this question, the Canadian Public Health Association, at the request of the Dominion Council of Health, made a survey in 1938 of all communities in Canada, including large cities. It was found that eighty-five communities, representing approximately 50 per cent of the estimated population of Canada, had the services of a full-time medical officer of health. The findings are presented in the Appendix (table I). As would be expected, the greater part of the population served in all the provinces, with the exception of Quebec, Prince Edward Island and New Brunswick, were urban populations. The percentage of the population in rural areas in the other provinces that had full-time health services was insignificant, constituting six per cent or less. Although additional full-time units have been established in Quebec and in several of the other provinces, and a few cities have been added to the list of the urban municipalities having full-time services, the data in this table present substantially the situation at the present time.

It is seen at once that approximately half the population of Canada is not at present provided with full-time local health services, and that very large sections of the country are without the services which are essential in health supervision. This need can be met through full-time health units. Such units, cannot, however, be provided by the local municipalities, but require direction and financial assistance from the provincial departments of health.

3. THE PRACTISING PHYSICIAN SHOULD PROVIDE BOTH PREVENTIVE AND TREATMENT SERVICES, AND REQUIRES ASSISTANCE FROM AN ADEQUATE LOCAL DEPARTMENT OF HEALTH

On many occasions the Canadian Public Health Association has expressed the desire of its members that the family physician should assume, as a responsibility for those under his care, certain preventive services, some of which are being furnished through departments of health. The Association believes that the responsibility for the maintenance of health and the prevention of disease should be shared by the physician in general practice whose professional duties are in the main exercised through the fundamental unit of society, namely the family.

Since the effectiveness of preventive measures may be lost unless action is taken as early as possible, the general practitioner, who is the first to see the patient, must inevitably play a most important part in the success or failure of preventive medicine. He is thus in a preferred position to initiate at the earliest possible moment the train of events, either through his own administrations or with the aid of experts, which lead most promptly and effectively to the control of the diseases which he encounters. The general practitioner has not always, in the past, either seized the opportunity or accepted the responsibility in an effective or realistic fashion. There are undoubtedly reasons, and these would largely be removed if the practice of preventive medicine formed an integral and essential part of health insurance. The general practitioner is hesitant, under present conditions of private practice, to advocate preventive services from which he will benefit financially. In other words, he does not wish to impose an extra burden upon the family for medical attention which has not been specifically requested. The patients of the general practitioner are often not sufficiently aware of the value of such supervision to request the physician to render preventive services for which payment would willingly be offered. Under health insurance the physician would receive remuneration for the services rendered in the practice of preventive procedures. A further reason is that family physicians are often not fully aware of the opportunities for service which preventive measures offer.

In the Submission of the Canadian Medical Association such an extension of services to be rendered by family physicians is outlined. The family physician can and should provide adequate prenatal supervision of the expectant mother, as well as care for her at the time of confinement. In addition to safeguarding the health of the mother and baby, he should continue to serve as the family health adviser, maintaining watchful supervision through the pre-school and school years, and if found practicable, continue such supervision into adolescence and adult life. As stated in the Submission of the Canadian Medical Association, "the family must be the unit."

In including a larger measure of preventive medical services in the practice of the family physician, provision must be made for the proper payment of such services. Payment on a per caput basis would greatly facilitate the rendering of such service by the physician. Reference to the subject of payment is made

in this Submission only because in the judgment of public health authorities payment on a fee basis for each service rendered would be impractical and tend to defeat the fundamental conception of the prevention of sickness and disability.

The Relationship between the Practising Physician and the Local Department of Health

If the general practitioner is to render such service, it is necessary that there should be a well-established community health service. In order that an adequate health program may be provided, there must be the closest relationship between the practising physician and the local department of health. Some preventive measures, such as school medical services, tuberculin testing and chest X-ray examinations, and the treatment of venereal diseases, may be more economically and conveniently provided through clinics or other group organizations arranged by the department of health and the practising physicians. Such provision calls for a complete understanding of the needs and resources of the community by the physicians and the health department. This can only be attained by an intimate relationship between the medical officer of health and the physicians of the community. Such a relationship would assure the success of the local health program and progress towards the common objective of good community health.

It is at once appreciated that the local department, through its health education program, informs the public of the essential preventive services which the family physician is prepared to render. Only in this way can the plan of having the family physician serve as a health adviser really function. In the effective working of the plan by which the general practitioner will render essential preventive services, it is obvious that supervision of the preventive activities of the general practitioner by a competent authority is essential. In the opinion of this Association, the physician qualified by post-graduate training in public health, serving as medical officer of health, is the logical authority for providing such supervision.

4. ADEQUATE LOCAL HEALTH DEPARTMENT SERVICES DEPEND ON PROVINCIAL HEALTH DEPARTMENTS FOR DIRECTION AND FOR FINANCIAL ASSISTANCE

The British North America Act provided the foundations of a national, centralized government and defined the respective responsibilities of the federal and provincial governments. The term "public health" was not in use at that time; in fact, it was not until 1875 that the great Public Health Act which gave prominence to this term was passed by the British Parliament. Only brief references are made to health matters in the British North America Act, and these place with the federal government the responsibility for the census and statistics, quarantine, and the establishment and maintenance of marine hospitals. All other responsibilities, including the establishment and maintenance of hospitals and asylums, are left to the provincial authorities. This would

seem to imply that treatment services are primarily the responsibilities of the provincial authorities.

The first provincial board of health in Canada was established in Ontario in 1884, thirty-five years before a federal department of health was created. The Public Health Act of 1875 of Great Britain provided for local health services for all communities under the central authority, and required that every municipality must appoint a physician to serve as medical officer of health, and also a sanitary inspector. The Public Health Acts of a number of the provinces in Canada made similar provisions, so that the general plan followed in providing local health services has been the appointment of a local board of health, a physician serving as health officer, and a sanitary inspector. The development of provincial departments of health has progressed rapidly since the close of the last war. New Brunswick, in 1917, was the first province in Canada to have a Minister of Health, and such a step has since been followed by a number of the other provinces. This is a significant development, in that health is represented in the provincial Cabinets.

Provincial Health Programs

Provincial health programs as undertaken by provincial departments of health may be considered as (a) directional, (b) consultative, (c) educational, and (d) direct service. In general, the program provides preventive services and treatment services. The Public Health Act and the other Acts with their regulations provide for the establishment of acceptable units of local public health service and for meeting the problems of environmental sanitation, control of communicable diseases, the supervision of milk and other perishable foods, and other public health responsibilities. As part of the *directional service,* the provincial department is responsible for setting up minimum standards in respect of qualifications of public health personnel employed both by provincial and local departments, for surveys of health needs, for the collection and tabulation of statistical data in respect of births, marriages and deaths and the extent of illness. Finally, the provincial department is responsible for the distribution of provincial and federal subsidies.

In providing *consultative services,* it is essential that the department be equipped with a well-trained staff so that direction may be given to the local community programs, particularly in such matters as the sanitary disposal of refuse and sewage and the provision of satisfactory water supplies. The departmental staff must be available to aid local authorities in the event of outbreaks of communicable disease and to provide general supervision of local services. Assistance is given also in the interpretation of government legislation.

Of great importance is the *educational service,* which may be considered as informative, relating to the preparation and distribution of informative material; and as promotional, serving to stimulate local authorities and others to the point where necessary services are established—for example, the establishment of larger units of local administration or services such as public health nursing, nutrition programs, etc.

Under *direct services,* the department provides central and branch laboratories for the examination, without charge, of bacteriological and other specimens. In all the provinces some plan is in effect to assist physicians in the treatment of certain communicable diseases through the supplying of the essential vaccines and serums for the prevention or treatment of smallpox, diphtheria, typhoid fever, scarlet fever, whooping cough, tetanus, and epidemic meningitis. In a number of provinces these products are made available to physicians without charge, and insulin is also supplied for needy diabetics. Diagnostic clinics for the detection of mental illness, tuberculosis, crippling, etc., constitute another direct service which is offered by provincial departments.

In so far as *treatment services* are concerned, provincial health programs have provided for the institutional care of the mentally ill and the feeble-minded, for the treatment in sanatoria of patients suffering from tuberculosis, and for the treatment of venereal disease. Provision is made also for the treatment of the major communicable diseases when these are present in epidemic proportions, such as outbreaks of infantile paralysis, epidemic meningitis, etc. In some of the provinces provision is made also for the care of cancer patients.

Such a program presupposes adequate funds, a suitable type of local administrative unit which is both geographically and economically sound, and the availability of sufficient personnel with the required qualifications.

Reviewing public health progress in Canada, it can well be said that the achievements are to a very large extent a record of achievements of provincial health departments.

The Inadequacy of Present Programs

To what extent are the provincial governments providing the type of provincial health program which has been outlined and which is considered to be a reasonable minimum?

An answer is to be found in part in the expenditures for so-called "public health purposes" made by the provincial governments. In a study of these expenditures for the year 1937, made at the request of the Dominion Council of Health, it was found that the provincial governments carry a very large burden of hospital costs, including general hospitals, mental hospitals, and tuberculosis sanatoria. Because of these large expenditures, the amount available to the provincial health department is definitely limited; and when considered from the standpoint of the provision of preventive services, it is entirely inadequate for the need. These data are presented in the Appendix in tables II, III, IV and V.

In table II the expenditures by provinces for health and for general and mental hospitals are given. Of the total expenditures for the nine provinces, amounting to approximately $22,000,000, about $6,000,000 represented expenditures for public health services and $15,000,000 represented hospital expenditures.

Table III presents data concerning expenditures for general and mental hospitals by each of the provinces. This indicates the very large expenditures for the maintenance of mental hospitals, representing 44 per cent of the total expenditure of $22,000,000 for all health purposes.

Table IV presents expenditures by provincial governments for health services, showing separately the expenditure for tuberculosis. It will be seen that the expenditure for tuberculosis equalled the total of all the other provincial public health expenditures. Of the total provincial health expenditures of approximately $6,000,000, $3,000,000 was required primarily for the treatment of tuberculosis.

From these tables it is evident that hospital costs constitute 84 per cent of the total provincial government health expenditures (mental hospitals 44 per cent, public hospitals 27 per cent, and tuberculosis sanatoria 13 per cent), leaving only 16 per cent for the maintenance of the provincial public health services. In referring to the large expenditure for tuberculosis, which equals the total of all the other expenditures of the provincial department of health for public health, there is no suggestion that less money should be spent on the reduction of this disease. It has been demonstrated clearly that tuberculosis death rates can be rapidly reduced if free treatment is provided in sanatoria and an adequate province-wide program of case-finding, including the examination of contacts, is undertaken. In Ontario the number of deaths from this disease has fallen from 3,484 in 1900 to 1,100 in 1941, in spite of the increase in the population from 2,183,000 in 1900 to 3,788,000 in 1941.

Table V presents the estimated expenditures which could be considered preventive, in contrast with treatment. These amount to approximately $2,000,000—or 9 per cent of the total health expenditures. It is striking that such a small percentage of the expenditures which are frequently referred to as "public health expenditures" is directed towards the prevention of disease, both physical and mental, and the forwarding of programs for the maintenance of health through a wider knowledge of nutrition, better sanitary conditions, better housing and other fundamental health requirements. There is general recognition of the need for more preventive services, but it is obvious that larger support must be made available through provincial governments if such services are to be possible. As previously stated, the very large burden of hospital costs placed upon provincial governments has prevented the provision of funds for the extension of preventive services by provincial departments of health. The application of preventive medicine has achieved outstanding success in reducing the number of deaths of mothers and infants, but here again the amount of money available in various provincial departments of health for such services is so small that only the larger provinces are able to provide suitable organizations with trained personnel to give direction. Nutrition and industrial hygiene are subjects which are constantly before us today, yet only one province in Canada has a division of nutrition, and the efforts in industrial hygiene have been severely limited by the funds available.

The inadequacy of the present preventive health services is generally recognized. In the Submission of the Canadian Medical Association it is stated:

"The present program of preventive medicine in the country is far from adequate. Our major emphasis in the past has been on the cure of disease—on negative health, as it were. There should be more emphasis in the future

on positive health, on preventive medicine and public health. It is less costly to prevent disease than to cure it, yet our progress in this direction, although steady and gratifying, has been far too slow.

"In making these statements there is no implication in the slightest that the provincial, federal and municipal departments of health have not done excellent work. Actually they have accomplished much, frequently under considerable handicap. But the results have been much less than could have been achieved had adequate funds been available. It is unfortunate that, while, in the past, money has been freely available for so many other purposes, yet so much difficulty has been encountered in obtaining adequate funds for effective programs of preventive work and public education on health matters."

It is when the present situation in regard to local health services is remembered that it is appreciated that little change from the present unsatisfactory conditions of inadequate service *can* be expected until financial assistance is provided. Generally, the communities most in need of more adequate service are the communities least able financially to provide it. In any case, they are the least likely to attempt to improve conditions unless assistance be given to them and direction provided. It is logical that such assistance and direction should be provided through the provincial government. But it is also obvious that the heavy expenditures by provincial governments for hospitalization and other costs limit their assistance to local communities.

The answer is to be found in a policy of grants-in-aid from the federal government to provincial governments, to permit of sharing the burden of certain diseases such as tuberculosis and the problem of mental illness, and to provide financial assistance to local communities for health services.

5. THE FEDERAL ROLE IN PUBLIC HEALTH

It was not until the close of the last war that Parliament created a federal department of health for Canada—the Department of Pensions and National Health. Prior to 1919, health activities were divided among the several departments of government, including Agriculture, Marine, Fisheries, and Inland Revenue. The control of tuberculosis was the responsibility of the Department of Finance and the Conservation Commission. A National Council of Health under the Conservation Commission advised the federal and provincial governments on health matters. Co-ordination was lacking. The Canadian Medical Association and the Canadian Public Health Association from time to time urged the federal government to create a federal department of health.

By the terms of the Act establishing the department in 1919, its duties and powers extend to "all matters and questions relating to the promotion and preservation of the health of the people of Canada", but it is expressly stated that the department shall not exercise any jurisdiction or control over any provincial or municipal board of health or other health authority operating under the laws of any province. In the Department of Health, Canada has therefore a department which assumes the statutory responsibilities placed upon

it by Parliament, and affords, through its divisions, technical advice and other assistance to the provinces. The creation of the department has fostered an intimate relationship between the provinces and the Dominion Government in health matters; and in this development the Dominion Council of Health—the advisory body representing the executive medical health officers of the provinces, with certain other representatives—has played an important part. The establishment of the department gave an impetus to the development of public health in Canada and each of the provincial governments enlarged and strengthened its department of health. As previously stated, however, local health services have generally continued to be inadequate.

The Responsibilities of the Federal Department of Health

Among the responsibilities of the Federal Department are maritime quarantine, medical inspection of immigrants, sanitation of common carriers, the administration of the Food and Drugs Act, the Proprietary and Patent Medicine Act, the Leprosy Act, certain sections of the Canada Shipping Act relating to the care of ill or disabled seamen, and certain sections of the Public Works Act. One of the most important responsibilities of the department is to maintain the quality of all foods and drugs. Canada has a most comprehensive Food and Drugs Act and an effective organization for its administration. Included in this responsibility is the supervision of serums and vaccines, vitamins, and certain glandular products, for which there are international standards. Control of these products is carried on by the Laboratory of Hygiene. One of the functions of the Laboratory of Hygiene, under the Act establishing the department, is the conduct of research. The Department of National Health co-operates with the Dominion Bureau of Statistics in the provision of vital statistics for Canada. The international responsibilities of the department include maritime quarantine, the control of narcotic drugs, and the sanitation of international boundary waters.

Although, as mentioned, the creation of the department resulted in the bringing together of the health activities formerly assumed by a number of departments of government, for obvious reasons the administration of the Animal Contagious Diseases Act and the Meat and Canned Foods Act, which have very definite public health aspects, was left with the Department of Agriculture. The health of Indians, including tuberculosis control, is at present a responsibility of the Department of Mines and Resources.

Grants-in-Aid for the Extension of Health Services

Although an interpretation of the British North America Act places the responsibility for treatment of disease with the provincial governments, the magnitude of the problem of certain diseases—for example, mental illness, tuberculosis, and venereal diseases—leads inevitably to their consideration as national problems. When the extent of the venereal-disease problem was recognized, at the time of the creation of the Department of Pensions and National Health in 1919, provision was made not only for the establishing of a division

of venereal-disease control but also for providing assistance to the provincial departments of health for the maintenance of treatment clinics. An amount of $200,000 was voted and distributed annually to the provincial departments during a period of years. Although the grants were withdrawn and the venereal-disease division disbanded in 1932, the value of grants to assist the provinces in essential public health work had been clearly demonstrated. It is encouraging that provision has been made in this year's estimates for the restoration of venereal-disease grants and that the division of venereal-disease control has been re-established. Lieutenant-Colonel D. H. Williams has been appointed to head this division, and also to direct the venereal-disease control program in the armed services. Thus it is possible for a unified civilian and military program to be carried forward from coast to coast. This is an example of federal leadership in public health, a type of service which the federal department can render and which could be duplicated with advantage in other fields of communicable disease control.

The policy of grants-in-aid, established in regard to venereal-disease control, should be broadened, as the extension of health services for all communities calls for assistance. Such financial aid from the federal government should be made available to all provinces meeting the reasonable requirements of the federal authorities, whether or not a province implements the health insurance plan.

It has been demonstrated in Great Britain that grants for public health purposes made by the central authority result in larger expenditures by local communities, with the consequence that greatly increased services are rendered. In other words, local communities have not paid less, but have contributed more, as a result of assistance from the central authority. In the United States of America, the provision of funds under the Social Security Act of 1937 has resulted in a striking advance in public health services in every state. What is of great significance is that the granting of federal funds to the states has resulted in greatly increased appropriations for public health being made both by state and municipal authorities. It cannot be said that federal assistance has diminished the extent of state participation in public health, or has reduced municipal expenditures. Federal participation has made possible effective programs in each state and has proved to be the only way of adequately dealing with this problem—namely, on a *national* basis.

6. THE ADMINISTRATION OF HEALTH INSURANCE AND PUBLIC HEALTH

The experience in Great Britain indicates that very definite advantages derive from the close integration of the administration of health insurance both with the central health authority and with the local health authorities. With the establishing of the Ministry of Health in 1919, provision was made for an intimate relationship in the administration of public health and health insurance. This is obtained through the administration of health insurance not only for England and Wales, but for Scotland and Northern Ireland as well, through

a joint insurance commission which in turn functions through the insurance division of the Ministry of Health.

In the Submission to this Committee by the Deputy Ministers of Health, administration through either a health insurance commission or a provincial department of health was suggested. The Canadian Public Health Association endorses this suggestion that choice of administration be given the provinces. If administration is provided through the provincial department of health, the Deputy Ministers recommended that provision should be made for establishing a separate division and for assuring the selection of a competent director. If administration is provided through a health insurance commission, they recommended that the commission consist of from three to five salaried members. In either plan, a strong provincial advisory council on health insurance, representative of all groups concerned in health insurance, should be provided. The Canadian Public Health Association approves of these recommendations and believes that administration through a health-insurance division of a provincial department of health best permits of the proper integration of health insurance and public health.

How the need for adequate health department services for the whole of Canada can be met has been thoroughly studied by the provincial departments of health. Their findings have been given to the Canadian Public Health Association's Committee on Full-Time Local Health Services. The Association is therefore able at this time to present a summary of these plans as submitted by each provincial department of health. To provide for those areas other than self-contained cities and metropolitan districts, 250 health units would be required. These units would require approximately 400 physicians with special training in public health, 1,500 public health nurses, and 500 sanitary inspectors, together with office assistants and other technical staff. The total expenditures to provide for these areas would not exceed $8,000,000. Today the estimated expenditures in rural areas for services provided by the 84 units now operating is approximately $1,500,000. Thirty-five urban units, including metropolitan health areas, would provide services for all the large centres of population. In this way no part of Canada would be without public health supervision.

In the plan of administration as proposed in Schedule B, constituting the Provincial Health Insurance Act, provision is made in section 42 (1) for the division of the province into "public health regions" and "health insurance regions", and in section 42 (2) for a unified administration of all public health and health-insurance services. These provisions, as well as the provision of section 42 (3) for the most appropriate division of the province into public health regions and health-insurance regions, are heartily endorsed by the Canadian Public Health Association, as they provide for the essential unification of these services. In this way, intimacy of relationship can be maintained between the practising physicians, hospitals, and the organized departments of health, and economy of administration effected.

7. QUALIFIED PUBLIC HEALTH OFFICERS, PUBLIC HEALTH NURSES, AND OTHER PERSONNEL ARE ESSENTIAL IN PROVIDING PUBLIC HEALTH SERVICES

Of fundamental importance is the providing of trained personnel to serve in public health departments. It is recognized that the medical officer of health is a specialist in the public health aspects of medicine and requires post-graduate training and experience in order to direct public health programs effectively. Similarly, it is necessary for nurses and other personnel to receive post-graduate or other special training in public health.

Experience in the United States and Canada in obtaining physicians with post-graduate training in public health has shown that it is necessary to give financial assistance in the form of fellowships. Post-graduate courses occupy from eight months to a year. In order that physicians may receive such special training, assistance has been found necessary, as the undergraduate course in medicine, with internship in hospital, occupies at least six years and there is little opportunity during the course to accumulate resources for post-graduate training. It must be remembered also that physicians engaged in public health work receive less in the way of remuneration than do their colleagues in practice, particularly those of the latter who are specialists. Because they are entering public services and receiving small salaries, it is reasonable that the state should assist with their post-graduate training in public health. Similar provision is desirable to make it possible for graduate nurses and sanitary engineers to obtain post-graduate training, and assistance is also required if properly qualified sanitary inspectors are to be available.

Provision should be made by the federal government to assure properly qualified public health personnel if the investment in local health services is to yield adequate returns.

8. THE IMPORTANCE OF MEDICAL RESEARCH TO HEALTH INSURANCE

When health insurance was introduced in Great Britain in 1911, provision was made that a small part of each contributor's annual payment should constitute a fund for the advancement of medical research. As a result of this foresighted provision, the Medical Research Council of Great Britain was established, the National Institute for Medical Research organized, and great progress made in medical research in the British Isles. As the years have passed, additional funds have been made available, which is ample evidence of the recognition of the value of this investment.

Little provision is made by the Dominion Government to further medical research in the universities and hospitals in Canada, apart from limited funds made available during the past few years through the National Research Council of Canada. The work of the Associate Committee on Medical Research, organized in the National Research Council just prior to the war, has demonstrated the importance of leadership in this field, as well as the need for greatly increased funds to support research. It will indeed be a most serious loss if,

in the provisions of national health insurance, no provision is made for medical research in Canada. Only by advances in our knowledge can more effective treatment and prevention be accomplished and health insurance be made economically possible and effective in its objective of better health for the people of Canada.

9. SUMMARY

The plan of health insurance outlined by the Canadian Public Health Association visualizes:

1. The benefits of health insurance afforded to every citizen of Canada.

2. The provision of adequate local health services for every community by physicians, dentists and nurses, and full-time local health departments.

3. The family as a unit, which would receive continuous health supervision and treatment when required, from the physician of choice, with adequate diagnostic facilities and the services of specialists provided to assist the family physician. (For the first time in any health-insurance plan the family physician would render health advice and would advance measures for the prevention of disease, as provision would be made for payment for both preventive and treatment services.)

4. The administration of health insurance federally through a Division of Health Insurance in the Department of National Health, under the Minister of National Health, thus permitting of the development of health insurance and public health in a co-ordinated and effective plan.

5. The administration of health insurance provincially through a Health Insurance Commission, or, preferably, through a Division of Health Insurance in the Provincial Department of Health, thus permitting of the closest relationship in the forwarding of a broad program of health.

6. The administration of health insurance and public health locally through the suitable division of each province into districts or regions organized as full-time health units for the provision of local health department services and for the local administration of health insurance.

7. The provision of grants-in-aid to provincial governments to further the control of such national problems as tuberculosis, venereal diseases and mental illness, and to permit of establishing full-time health units to serve all parts of each province. Such a policy should be implemented either as a part of national health insurance or independently, in view of the evident need.

8. The provision of assistance, through fellowships, for the training of public health personnel, including medical officers of health, public health nurses, sanitary engineers, and sanitary inspectors.

9. More adequate provision for medical research in Canada.

APPENDIX

TABLE I

FULL-TIME† LOCAL HEALTH SERVICES IN CANADA, 1938, BY PROVINCES

Province	Population Estimated	Full-Time Departments			Population Served			Per cent of Total Population		
		Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural
British Columbia	761,000	6	2	4	397,305	354,823	42,482	52.0	46.5	5.5
Alberta	783,000	4	2	2	209,774	174,613	35,131	26.7	22.2	4.5
Saskatchewan	941,000	2*	2	0	95,502	95,502	.....	10.1	10.1	....
Manitoba	720,000	4*	3	1	280,554	256,286	24,268	38.9	35.5	3.4
Ontario	3,731,000	14	13	1	1,501,890	1,408,690	93,200	40.2	37.9	2.4
Quebec	3,172,000	42	5	37	2,362,321	1,131,694	1,230,627	74.6	35.8	38.8
New Brunswick	445,000	10	..	..	445,000	.....	.....	100.0	....	....
Nova Scotia	548,000	2	1	1	203,000	70,000	133,000	37.0	12.8	24.2
Prince Edward Island	94,000	1	..	..	94,000	.....	.....	100.0	....	....
CANADA	11,195,000	85	..	..	5,589,316	.....	.....	50.0	....	....

†Full-Time Medical Officer of Health.
*Excluding Municipal Physicians.

TABLE II

EXPENDITURE FOR HEALTH AND HOSPITALS BY PROVINCIAL GOVERNMENTS, 1937

Province	Population	Provincial Health Expenditure	Provincial Hospital Expenditure	Total Expenditure Health and Hospitals	Per Caput Expenditure
Prince Edward Island	93,000	$85,160.49	$100,214.00	$185,374.49	$1.99
Nova Scotia	542,000	421,553.23	588,253.17	1,009,806.40	1.86
New Brunswick	440,000	306,060.00	99,186.00	405,246.00	.92
Quebec	3,135,000	1,294,428.20	3,145,718.36	4,440,146.56	1.42
Ontario	3,711,000	1,833,187.50	4,922,819.65	6,756,007.15	1.82
Manitoba	717,000	396,864.31	1,150,498.00	1,547,362.31	2.16
Saskatchewan	939,000	596,408.00	1,933,040.00	2,529,448.00	2.69
Alberta	778,000	535,909.62	1,205,942.46	1,741,852.08	2.24
British Columbia	751,000	837,594.46	2,266,990.00	3,104,584.46	4.13
Total	11,106,000	$6,307,165.81	$15,412,661.64	$21,719,827.45	$1.96

TABLE III

EXPENDITURE FOR GENERAL AND MENTAL HOSPITALS BY PROVINCIAL GOVERNMENTS, 1937

Province	Population	Expenditure for General Hospitals excluding	Expenditure for Mental Hospitals	Total Hospital Expenditure	Per Caput Hospital Expenditure
Prince Edward Island	93,000	$10,000.00	$90,214.00	$100,214.00	$1.08
Nova Scotia	542,000	339,923.80	248,329.37	588,253.17	1.09
New Brunswick	440,000	20,288.00	78,898.00	99,186.00	.23
Quebec	3,135,000	1,645,718.36	1,500,000.00	3,145,718.36	1.00
Ontario	3,711,000	1,457,099.88	3,465,719.77	4,922,819.65	1.33
Manitoba	717,000	289,565.00	860,933.00	1,150,498.00	1.60
Saskatchewan	939,000	623,040.00	1,310,000.00	1,933,040.00	2.06
Alberta	778,000	469,936.70	736,015.76	1,205,942.46	1.55
British Columbia	751,000	1,020,386.00	1,246,604.00	2,266,990.00	3.02
Total	11,106,000	$5,875,947.74	$9,536,713.90	$15,412,661.64	$1.39

TABLE IV

EXPENDITURE FOR HEALTH SERVICES BY PROVINCIAL GOVERNMENTS, 1937

Province	Population	Provincial Health Expenditures excluding Tuberculosis	Provincial Health Expenditures for Tuberculosis	Total Provincial Health Expenditures	Per Caput Health Expenditure
Prince Edward Island	93,000	$46,968.86	$38,191.63	$85,160.49	$ .92
Nova Scotia	542,000	117,823.91	303,729.32	421,553.23	.78
New Brunswick	440,000	128,672.00	177,388.00	306,060.00	.70
Quebec	3,135,000	736,112.20	558,316.00	1,294,428.20	.41
Ontario	3,711,000	1,075,784.75	757,402.75	1,833,187.50	.49
Manitoba	717,000	234,511.31	162,353.00	396,864.31	.55
Saskatchewan	939,000	291,600.00	304,808.00	596,408.00	.64
Alberta	778,000	217,461.14	318,448.48	535,909.62	.69
British Columbia	751,000	262,162.08	575,432.38	837,594.46	1.12
Total	11,106,000	$3,111,096.25	$3,196,069.56	$6,307,165.81	$ .57

TABLE V

PREVENTIVE HEALTH SERVICES AS PERCENTAGE OF TOTAL EXPENDITURE FOR HEALTH AND HOSPITALS BY PROVINCIAL GOVERNMENTS, 1937

Province	Tota Expenditure for Health and Hospitals	Preventive Services (estimated)	Per cent Prevention (estimated)
Prince Edward Island	$185,374.49	$13,060.00	7.0
Nova Scotia	1,009,806.40	124,526.08	12.3
New Brunswick	405,246.00	135,708.60	33.5
Quebec	4,440,146.56	407,713.93	9.2
Ontario	6,756,007.15	562,051.30	8.3
Manitoba	1,547,362.31	127,141.00	8.2
Saskatchewan	2,529,448.00	210,955.00	8.3
Alberta	1,741,852.08	168,285.03	9.7
British Columbia	3,104,584.46	184,049.80	5.9
Total	$21,719,827.45	$1,933,490.74	8.9

Proposed Measures for Health Insurance in Canada*

THE PLAN FOR DOMINION-PROVINCIAL LEGISLATION PRESENTED TO THE SPECIAL COMMITTEE ON SOCIAL SECURITY OF THE HOUSE OF COMMONS

A PLAN for health insurance in Canada was presented for study and consideration to the House of Commons Committee on Social Security by the Honourable Ian Mackenzie, Minister of Pensions and National Health, on March 16th.

The plan was contained in the report of the Advisory Committee on Health Insurance (appointed February 5, 1942, by Order in Council P.C. 836, and under the chairmanship of Dr. J. J. Heagerty, Director of Public Health Services), and is in the form of specific proposals for Dominion and provincial legislation.

It would provide to all citizens complete medical and nursing services, hospitalization, medicines and drugs, and dental care.

Every adult would contribute to the program according to a scale based on capacity to pay, at a cost not exceeding $26 a year, or 50 cents a week per person over sixteen—no contributions would be required for children. Contributions would be collected where possible by payroll deductions.

The plan also envisages a public health program designed to prevent illness to the fullest possible extent, and to raise standards of health throughout the country.

Administration of the Program

In presenting the report, the Minister referred to the constitutional question as to whether public health matters come under Dominion or provincial jurisdiction. He was of the opinion that the constitution, "as at present understood and interpreted, prevents the Dominion Parliament from adopting a single comprehensive national health insurance act."

Accordingly, he pointed out, the Advisory Committee had proposed that the administration of health insurance be allotted to the provinces, with the Dominion Government providing financial assistance. It was recommended that a federal statute be passed under which the Dominion Government would assist financially any province which enacted a health insurance measure along approved lines. It would be provided, however, that no aid should be given unless the province also agreed to undertake a general public health program approved by the Dominion. This stipulation was made in the belief that health insurance needs to be accompanied by preventive health measures in order to be of the greatest public benefit.

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DRAFT BILL

The Report of the Committee contains a draft Dominion bill, which includes within it a model provincial bill. Scope is allowed the provinces, however, to alter the bill in respect of various details.

A summary of the proposals contained in the draft bill follows:

Coverage

The draft Health Insurance Bill is planned to include all persons resident in Canada. Nevertheless, no compulsion is placed upon the provinces in this respect, other than that all indigents must be included in the plan.

Health Insurance Fund

To provide health insurance, it will be necessary to create a Health Insurance Fund comprising money contributed by insured persons, employers, the provincial government and the Dominion Government. By so distributing the cost, the financial burden will be considerably lessened.

The payment of contributions has been so devised that each adult in receipt of wages or income will contribute on behalf of himself and his dependents over 16 years in proportion to his earnings. He will not, however, be required to contribute for children under 16, the cost of whose care is to come out of the general fund. If employed, his contributions will be deducted from his payroll; if his income comes from other sources, he will be assessed for the amount.

The contribution is estimated at $26 per person. If a person is capable of paying the entire cost for himself and his dependents, he shall be obliged to do so. However, in cases where the contribution would exceed three per cent of his income he will not be asked to pay the full amount. If he is a wage-earner, his employer will pay the difference; if not, the province will do so. The combined contributions will be supplemented by a Dominion grant.

Registration

As soon as health insurance is adopted in a province, all residents will be registered and classified and will be instructed to select a doctor from a list provided after consultation between the Provincial Health Insurance Commission and the authorized medical body.

The method of payment of physicians, nurses and others will be left to the decision of the Provincial Health Insurance Commission, but it is suggested by the Advisory Committee on Health Insurance that payment on a capitation basis would facilitate the provision of medical benefits. Also, the physician will have a responsibility for the health of each member of the family and be responsible for public health measures designed to reduce morbidity and mortality. He will act as counsellor, adviser and supervisor in respect of the health of the whole family as a unit.

Benefits

The benefits comprise prevention of disease and the application of all necessary diagnostic and curative procedures and treatments, including medical,

surgical, obstetrical, dental, pharmaceutical, hospital and nursing benefits and such other ancillary services as may be deemed necessary. Provision is not made for cash benefit due to unemployment caused by illness, as it is considered that such benefit should be provided by Unemployment Insurance or by other means.

Medical benefits include the services of a general practitioner, consultant, specialist, surgeon, obstetrician, nurse and hospitalization. Nursing in the home is confined to the visiting nurse except where the circumstances are such that bedside nursing is essential.

Dental benefit must of necessity be restricted, as the number of dentists in Canada is at present insufficient to provide full and complete care for all. It is proposed that the Provincial Dental Association make an arrangement with the Provincial Health Insurance Commission to provide every child up to sixteen years of age with a semi-annual dental examination and such reparative dentistry as is needed. Dental care may be provided others to the extent that the funds and the number of available dentists will permit.

Pharmaceutical benefit will be provided in accordance with a list of drugs to be drawn up in co-operation with the Provincial Health Insurance Commission and the Provincial Pharmaceutical Association. Special provision may be made respecting drugs and pharmaceutical preparations known as specialties.

Hospital benefit is to include general ward services unless the insured person wishes by paying the difference to obtain a semi-private or private room. In special cases accommodation other than general ward may be provided. The terms of agreement for hospitalization will be arranged by the Provincial Health Insurance Commission with the Provincial Hospital Association.

Nursing benefit, outlined above, will be provided by the Provincial Health Insurance Commission in co-operation with the Provincial Nursing Association.

Administration

Provision is made for administration through a Health Insurance Commission in each of the provinces, comprising a chairman who shall be a doctor of medicine, the Deputy Minister of Health of the province (ex-officio), and such other number of persons as may be determined from time to time by the Lieutenant-Governor in Council after consultation with representatives of professional groups, labour, agriculture, industry, etc.

Authority is given the Provincial Health Insurance Commission to study the resources of the province and facilities available for providing benefits and to divide the province into administrative and public health areas. The supervision of the provision of benefits is to be placed under regional officers.

Inasmuch as Dominion administration is confined to the administration of Dominion grants, it is not considered necessary to create a Dominion Health Insurance Commission, as administration may be carried out by a Health Insurance Division in the Department of Pensions and National Health under a Director of Health Insurance.

Provision is also made in the Bill for the creation of a National Council on Health Insurance, comprising the Director of Health Insurance of the Depart-

ment of Pensions and National Health as Chairman, the Deputy Minister of Health of each province, the Chief Administrative Officer of each province which has established a Health Insurance Act, and such other persons comprising a representative of the Canadian Medical Association, the Canadian Dental Association, Canadian Hospital Council, the pharmacal and nursing professions, labour, industry, agriculture and urban and rural women respectively, as may be appointed by the Lieutenant-Governor in Council. None of these will receive remuneration but will be paid travelling expenses and maintenance.

Grants

The bill would authorize the Dominion to make agreements with the provinces to assist them with grants of money in providing various health services in addition to health insurance.

Eight such grants are proposed, under the stipulation that the province make statutory provision for their economic and efficient use. In no case, however, is an agreement to be made with any province unless the province agrees to use both the Health Insurance Grant and the Public Health Grant.

Health Insurance Grant: To assist the provinces in providing health insurance benefits.

Tuberculosis Grant: This grant is designed to help provide free treatment for all persons suffering from tuberculosis, including the provision of additional buildings and bed accommodation. The reduction of mortality in those provinces which provide free treatment indicates that the provision of free treatment is essential to the elimination of tuberculosis.

Mental Disease Grant: To assist in the provision of free treatment for those suffering from mental illness, including the provision of additional buildings and bed accommodation. In this field the Committee considers that Dominion assistance is urgently needed.

General Public Health Grant: The object of this grant is to assist the provinces in establishing and maintaining public health services commensurate with the needs of their people.

These services are listed. They include: increasing facilities for the control of communicable disease and for the free distribution of vaccines, serum, etc.; dissemination of educational information in the field of public health; food and drug control; nutritional services; increase of laboratory facilities; improvement of the health and welfare of industrial workers; and other items.

It is proposed that the Dominion should make this grant to the people of Canada on a per caput basis, justified by the responsibility of the Dominion for public health problems that are national in character.

Venereal Disease Grant: To aid in providing preventive and free treatment for persons suffering from venereal diseases on the same basis as the original Dominion venereal disease grant of $200,000 which was discontinued in 1932.

Grant for Professional Training: As the name implies, this grant is to afford financial assistance to doctors, sanitary engineers and others who wish to take university courses leading to degrees in public health.

Investigational Grant: To enable the provinces to carry out special public health studies, funds are needed. It has been found impossible to carry out studies in public health and to provide skilled personnel during epidemics because of lack of funds.

Physical Fitness Grant: The creation of a physical fitness plan to prevent physical defects is considered essential.

Cost of the Program

One entire section of the Committee's report is devoted to estimates of the cost of health insurance in Canada.

The total cost of a year's operations on the known population figures for 1938 is calculated to be $232,896,000; to which must be added the cost of administration, $23,290,000; making a total of $256,186,000.

It is estimated that the total of contributions from beneficiaries and employers would amount to $124,750,000. This would leave $131,436,000 to be met jointly from the Dominion and provincial treasuries. Several alternative proposals are made in the report as to the proportions of the costs which might be assumed by each government.

In addition, it is proposed that the public health grant, without the acceptance of which it is recommended that there should be no federal assistance to health insurance, should be at the rate of 25 cents per caput, which would aggregate $2,872,428 to be paid out by the Dominion to the provinces.

SCOPE OF THE REPORT

The complete report of the Advisory Committee on Health Insurance is in seven parts, as follows:

Part 1, the draft bill and a summary of its contents;

Part 2, historical survey of health insurance throughout the world;

Part 3, a summary of the provisions of health insurance in operation in the various countries throughout the world at the present time;

Part 4, a report on existing public health agencies in Canada;

Part 5, a statistical survey of public health in Canada;

Part 6, estimates of the cost of health insurance for Canada;

Part 7, submissions by various organizations to the Advisory Committee on Health Insurance;

And an appendix containing miscellaneous useful information.

The report is available at a cost of $1.50 from the King's Printer, Ottawa.

EDITORIAL SECTION

PROPOSED MEASURES FOR NATIONAL HEALTH INSURANCE

DURING the past four months the Special Committee on Social Security of the House of Commons has held hearings for the presentation of the views of interested groups. Thus far the evidence has been confined to the plan submitted for national health insurance.

At the opening session, held on March 16th, the Honourable Ian A. Mackenzie, Minister of Pensions and National Health and Chairman of the Cabinet Committee on Reconstruction, tabled three reports: the report of the Advisory Committee on Health Insurance, which was prepared under the direction of Dr. J. J. Heagerty; a report on social security for Canada, prepared by the Committee on Reconstruction (Dr. L. C. Marsh's report); and a proposed draft bill for the promotion of physical fitness of the people of Canada. The report on social security was briefly outlined, and the Minister then dealt with the provisions of the proposed health insurance bill. Particular reference was made to the preventive program, including public health education. The Honourable Mr. Mackenzie stressed, as a second fundamental, the fact that the provisions must be extended to the entire population. The plan must also provide for a contributory system. The Minister's presentation was a most comprehensive one, and much essential detail, as well as the broad principles, was outlined.

The second and third hearings of the Special Committee were devoted to a more detailed consideration of the bill by Dr. J. J. Heagerty, Director of Public Health Services, Department of Pensions and National Health, and Mr. A. D. Watson, Chief Actuary of the Department of Insurance. Those who attended the sessions have been impressed by the comprehensiveness of the study made by the Advisory Committee, and by the splendid manner in which Dr. Heagerty has brought these findings to the attention of the Special Committee in reply to various questions during the hearings. The report of the Advisory Committee constitutes a volume of 558 pages and contains all the essential data on the subject of health insurance. Dr. Heagerty and the members of his Committee deserve the highest commendation for this masterful study.*

**Copies of this report—"Health Insurance," Report of the Advisory Committee on Health Insurance appointed by Order in Council P.C. 836 dated February 5, 1942—can be obtained from the King's Printer, Ottawa. The price is $1.50.*

Since health insurance is of such vital interest, the Editorial Board believes that the presentations of the Canadian Medical Association and other organizations should be made available for all who are concerned in public health work. In this issue appear the presentations of the Canadian Medical Association and the Canadian Public Health Association.

It is significant that both presentations are in complete agreement not only in support of health insurance but also in regard to the broad principles enunciated for the provision of adequate health supervision. Members of the Special Committee on Social Security of the House of Commons have remarked on the unanimity of the opinion expressed by physicians, public health workers, and laymen alike, that preventive medicine and public health must be given a leading place in any plan of health insurance. Not only did the presentations of both organized medicine and public health agree concerning the need for the practice of preventive medicine and the advancement of public health, but both offered the same solution; namely, the inclusion of a larger measure of preventive service in the work of the general practitioner. Such presentations from the two official bodies of physicians and public health workers would not have been possible even a decade ago. Now there is a growing appreciation of the fundamental fact that medicine cannot be separated into its curative and preventive aspects.

It is planned to publish, in succeeding issues of the JOURNAL, the presentations of other organizations. Each outlines the essential needs of health insurance as the groups concerned see them, and presents the considered opinions of experts in each field.

THE THIRTY-SECOND ANNUAL MEETING OF THE CANADIAN PUBLIC HEALTH ASSOCIATION

RECOGNIZING the increasing demands on the physician's time, and the serious situation in government and municipal departments of health, the Canadian Public Health Association is limiting its thirty-second annual meeting to a two-day conference, to be held in Toronto during the first week of October.

The Executive Council will hold an important session which will permit of a full discussion of problems relating to the present functioning of health departments, as well as consideration of the place of public health and preventive medicine in health insurance and post-war needs. The Public Health Nursing Section will hold the only sectional meeting. All Sections will unite in the general sessions which will occupy Monday afternoon and Tuesday, October 4th and 5th. One of the features of the meeting will be short but comprehensive outlines of the newer knowledge in each of the important fields of public health. Plans which will permit of adequate health supervision for the whole of Canada, through the organization of urban and rural full-time health units, will be outlined by representatives of the various provinces. The integration of curative and preventive medicine in health insurance will also be discussed, and the present position of health insurance reviewed.

WILLIAM WARWICK, M.D., C.M., D.P.H.

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PUBLIC health workers throughout Canada have learned with great regret of the passing of one of their distinguished colleagues, Dr. William Warwick, who died suddenly at Fredericton on May 29th. In May 1940 ill health had caused his retirement as Chief Medical Officer for the Province of New Brunswick, after eight years of able service in that capacity and twelve years as district medical officer. In the planning of the Ministry of Health for New Brunswick in 1917, and in the development of the public health program for the province, Dr. Warwick gave most valuable assistance to the Honourable William F. Roberts, Minister of Health, and to Dr. George Melvin, Chief Medical Officer, and was instrumental in maintaining a high standard of health service for the province.

Dr. Warwick was born in Saint John in 1881. He graduated from McGill University in 1904 with the degree of M.D., C.M., and engaged in private practice at Westfield and Saint John. In 1911 he became bacteriologist for the Federal Government quarantine service at Saint John. Two years later he returned to McGill University to take the course leading to the Diploma in Public Health. In 1915 he went to England as medical officer of the 115th Battalion and subsequently to France as a major with the 5th Canadian Mobile Laboratory. After serving in France until February 1919, he returned to Canada in August, assuming the post of pathologist and bacteriologist for the quarantine service of the Federal Government in Saint John. In January 1920 he joined the staff of the Provincial Department of Health as southern district medical officer, serving the city and county of Saint John and the counties of Charlotte, Kings and Queens. Dr. Warwick was the executive officer for Dr. Roberts in promoting the many health services established in Saint John, and served as medical director of the Saint John Health Centre. Medical inspection of schools, pasteurization of milk, and the clinic services of the Health Centre were all inaugurated during the period of Dr. Warwick's service in Saint John.

On the retirement of Dr. Melvin in 1932, Dr. Warwick became Chief Medical Officer for the Province, at Fredericton. Under his leadership increased support was obtained for the department, making possible the division of the province into ten health districts, each under the direction of a full-time medical officer. Medical inspection of schools was extended, and the efforts for the control of tuberculosis were greatly strengthened by the appointment of physicians with special training in tuberculosis control to serve as district health officers. His keen interest in statistics enabled Dr. Warwick to serve

most efficiently as Registrar General of Vital Statistics, as well as Chief Medical Officer.

After his retirement in 1940 Dr. Warwick continued to reside in Fredericton, and his wealth of knowledge of public health administration was still available to the department.

Dr. Warwick served as President of the Canadian Public Health Association in 1933 and was a member of the Executive Council for many years. At its annual meeting in 1942 the Association conferred honorary life membership upon him in recognition of his significant contribution to the advancement of public health in Canada.

Dr. Charles W. MacMillan, who succeeded Dr. Warwick as district medical officer for the southern area, and again as chief medical officer for the province, has paid this tribute to Dr. Warwick: "His whole heart was in the advancement of public health, and in its administration he was unsurpassed."